EXHIBIT “2”

CORVEL

June 1, 2023

Leibel Law
Steven Leibel, P. C.
3619 Chestatee
Dahlonega, GA 30533

Re:

Your Client:	Laura Alevy
Date of Loss:	4/3/2023
Our Client:	Bed Bath & Beyond Store 473 (Cummings, GA)
Claim Number:	0981-GL-24-0300102-001
Carrier/Underwriting Co.:	Safety National

Dear Steven Leibel, P. C.:

CorVel Corporation is the authorized Third Party Claims Administrator for Safety National assigned to review and adjust claims on behalf of their insured Bed Bath & Beyond Store 473 (Cummings, GA).

We are in receipt of your letter of representation dated 4/14/2023. Please provide the following requested information for your client:

1. Full name, address, date of birth and social security number.
2. Detailed statement of the facts and/or a recorded statement from your client;
3. List of all witness names, addresses and phone numbers;
4. Any photos and/or videos related to this loss;
5. The theory of liability against the above named client;
6. A list of the alleged injuries. Please include specific medical diagnosis, treatment, bills, all treating medical providers, and their contact information.
7. If a wage loss claim is being asserted, please include the employer's contact information;
8. Any additional information related to this claim supporting your position.

Additionally, enclosed is a HIPAA compliant release of medical information form to obtain copies of your client's medical records and bills. Please return the signed form to assist in obtaining the information if it is not attached in your reply.

Also enclosed is the Medicare Authorization form required to report this information to The Centers for Medicare and Medicaid Services (CMS).

Please feel free to contact the undersigned with any questions.

Sincerely,

Sandra Hazelton | Liability Claims Specialist
CorVel Corporation | Charlotte, NC
PO BOX 78059, Charlotte, NC 28271
DD 704.941.2870 | TF 800.365.5998 Ext. 12870 | F 866-517-1459
Sandra_Hazelton@CorVel.com | www.CorVel.com

Intentionally providing false information in pursuit of insurance claims or claim payments is criminal. Please follow this link for your state specific information: https://www.corvel.com/state-legislation/claim-fraud-warnings/

(Enclosure)
[Attach Medicare Document]
[HIPAA Release]
[Preservation of Evidence]

Request for Preservation of Evidence

Please consider this Bed Bath & Beyond's formal request and demand for preservation of documents, items and/or evidence. Please instruct your client(s) to preserve any and all documents, tangible things, and electronically stored information potentially relevant to any claims or issues arising from the subject of this incident.

Since this claim is in its infancy, all relevant documents and things cannot be specifically identified at this time. Please preserve any and all evidence related to the claims in this matter in its native form.

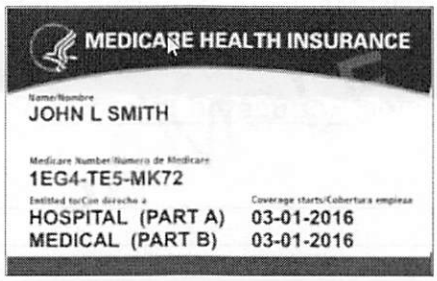
Please be advised should you purge, dispose of, destroy, lose, give away, or permanently alter any material evidence related to the subject incident, this may constitute spoliation of evidence, in which case you could be subject to evidentiary or monetary penalties and/or sanctions in accordance with <incd4> Law.

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	□ Yes	□ No
If yes, please complete the following. If no, proceed to Section II.		
***Full Name:** (Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)** / /	
****Social Security Number:** (If Medicare Number is Unavailable) - -	**Sex** □ Female	□ Male

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Medicare Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) **Medicare Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form **Date**

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State and Zip Code

RE: Patient Name: Laura Alevy
Date of Birth: _____ Social Security Number: _____
Claim #: 0981-GL-24-0300102-001

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ Medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers for the period _____ to _____.

☐ Physical, occupational and rehab requests, consultations and progress notes for the period _____ to _____.

☐ Disability, Medicaid or Medicare records including claim forms and record of denial of benefits for the period _____ to _____.

☐ Employment, personnel or wage records for the period _____ to _____.

☐ Autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports for the period _____ to _____.

☐ Pharmacy/prescription records including NDC numbers and drug information handouts/monographs for the period _____ to _____.

☐ Billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Sandra Hazelton
Name of Representative

Adjuster
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

PO Box 78059
Street Address

Charlotte, NC 28271
City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date